

## ADVANCE MEDICAL DIRECTIVES

### PERSONAL INFORMATION

DATE: \_\_\_\_\_

1. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated or about to divorce			
2. Military Status <input type="checkbox"/> Active Duty <input type="checkbox"/> Family Member of Active duty <input type="checkbox"/> Retired/Family Member			
3. Name (First, Middle, Last)		Your Soc. Sec. No.	Date of Birth
4. Home Address (Number, Street)		City	State    Zip
5. Mailing Address If Different From Above (Number, Street)		City	State    Zip
6. Home Phone (    )	Work Phone (    )	Cell Phone (    )	
7. State of Legal Residence (where you vote and pay taxes):			

### A LIVING WILL

1. A Living Will makes your wishes known to family and doctors regarding life support and other medical decisions in the event you become terminally ill or injured with no hope for recovery. Do you want a living will?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Upon your death, do you wish to donate your organs:	
For transplants	<input type="checkbox"/> Yes <input type="checkbox"/> No
For science or medical research	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. If practical, do you want your family to remove you from a hospital or nursing home so you can die at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you want artificially administered hydration and nutrition continued?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1. A <b>Durable Power of Attorney for Health Care</b> gives broader protection. Do you want to appoint someone (spouse, adult child, or friend) to make health care decisions for you if you are unable to, but not necessarily terminal? If so provide the following information:	
2. <b>First Agent:</b>	
Full Name (First, Middle, Last)	
Address	
Phone Number: Home: (    )	Work: (    )
Relationship	
3. <b>Second Agent</b> (Initial to right if second agent not desired) <b>NO Alternate</b>	
Full Name (First, Middle, Last)	
Address	
Phone Number Home: (    )	Work: (    )
Relationship	
4. If you have named an second agent, in what order do you want your agent(s) to act ( <b>select YES on only ONE</b> ):	
Agents may both act, and act separately from one another.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Agents must act together (unless one is incapacitated).	<input type="checkbox"/> Yes <input type="checkbox"/> No
Agents are to act in order as shown (primary and alternate).	<input type="checkbox"/> Yes <input type="checkbox"/> No

Your documents will be prepared, you will review them and execute them with witnesses, and a Notary Public, if required.